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Assessing and Meeting the Needs of Homeless Populations

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ASSESSING AND MEETING THE NEEDS OF HOMELESS POPULATIONS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

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ABSTRACT

Problem Formation: As homeless populations have continued to grow, it is important to analyze services and replace ones lacking efficacy. This research sought to locate gaps in service delivery and to let the data fuel newer, innovative services. **Significance:** This study brought greater awareness of needs and services available to homeless people and to clinical staff at the agencies who work with them. It also provided new ideas for interventions that might better meet client needs. **Design:** This study was designed as a mixed-methods project. It was believed that master's level social work students would be an ideal group to gather data on the needs, service efficacy, service barriers, and ideas for better services. Sampling was done utilizing purposeful sampling. **Analysis:** Data was analyzed using a bottom-up approach with no expectation of the data provided by participants. Data was categorized by interview question, and common themes were identified as connections were made. **Findings:** The most notable finding was that the bureaucracy of service providers was a significant limiting factor in serving this population. It was also found that while interventions succeeded at temporarily meeting physiological and safety needs, longer term and higher client needs were not being met**. Implications:** Interview respondents were new social workers, working or interning in the field, and the study findings provided valuable data to seasoned and new social workers about the service gaps found as well as the new services and interventions envisioned by the study participants. **Keywords:** homeless, needs, services, interventions, efficacy.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

There is a large homeless population in the State of California and these individuals seek and rely upon services provided by many different organizations. According to the HUD Office of Policy and Research (2020), the homeless population in America has continued to increase for the last twenty years and it is expected to continue as rising housing costs (California's High Housing Costs – Causes and Consequences, 2015) continue make it difficult for people to afford housing in their communities.

As the homeless population continues to increase, it has become more important to determine the efficacy of services being provided to them. This study sought to obtain a better understanding of the behavioral and mental health services available to the individuals in the homeless community, as seen by clinicians who currently work with this population in their internship or regular employment, and who are also currently working on their Master of Social Work (MSW) degree at California State University San Bernardino.

Purpose of the Study

Because homeless individuals are a minority group that is lacking in social or political power, the agencies and clinicians who serve them have an ethical responsibility to lessen the effects of this unbalanced dynamic and work diligently

toward providing the best level of care to these individuals when providing clinical or case management services (Toro et al., 1997). The goal of this study was not only to get an understanding of the services and interventions available, but to determine which ones are working, which ones are not, and to identify new services and interventions based on the gaps in services discovered through the study. To provide the most effective services to the homeless population, it is important to understand the available services and their viewed efficacy as seen by clinicians who work regularly with this population. As many MSW students are already employed in clinical and case management roles, these study participants were chosen because MSW students are in the process of growing their knowledge base and can develop ideas for solution-focused solutions where they see them to be currently lacking.

Significance for the Social Work Field

The need to conduct this study began with the researcher's desire to evaluate the needs of homeless individuals and to determine if existing services being provided in both inpatient and outpatient settings were sufficient to ameliorate the problems homeless individuals experience. As the number of homeless individuals has continued to increase, the research in this field has not kept up with the changing landscape of homelessness, so the concept for this study came about to fill the knowledge gaps.

In order to make a difference in the lives of homeless individuals, this study sought to determine the needs the population presented with, the services

currently being provided, and to determine which services were successful and which were not, and to seek out new and innovative interventions to be implemented and subsequently evaluated for their efficacy. California has greater resources than many nations and has the ability to provide better services to the homeless population if government, state agencies, and potential donors support the betterment of the lives of homeless individuals. It is hoped that the results of this study will help to garner the support of these stakeholders. As a result of this study, at a minimum, greater awareness and knowledge of the homeless situation here in the State of California will come about because of this study. On a larger scale, it will add to the dearth of qualitative research data that is available about the lives of homeless people, the services available to them, and innovative ideas for better interventions.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The incidence of homelessness in California is a microcosm of homelessness around the United States and in other countries. Hundreds of thousands of people are homeless in the United States at any given time and these numbers are likely under-reported. There are many likely causes and contributors to homelessness, but the literature review showed the most prevalent causes to be: mental health and lack of services, substance abuse, poverty and job loss, family breakdown, and lack of affordable housing.

The impacts and consequences of homelessness can be looked at from a micro and macro perspective. Homeless individuals have few, if any, social connections to family and friends and are ostracized from society. They experience loneliness, isolation, stigma, ostracization, health problems, and shortened life spans. Society is impacted by homelessness in terms of costs, which include emergency room visits and the costs associated with criminalizing homelessness. Other societal consequences include costs to provide medical care, often in emergency room settings, decreases in property values near areas with large homeless populations, and loss of tax revenue because much of the homeless population is not in the workforce. While there are prevention programs that are already in place to prevent homelessness, they have not been able to even begin to eradicate homelessness. Up until recently the focus on intervention

was to provide immediate need/emergency services such as the ones provided at emergency shelters, but there appears to be a trend toward solutions such as residential programs, job training programs, mental health treatment, and educational programs, all of which are designed to help individuals over long periods.

Prevalence of Homelessness

During the process of gathering data for this literature review, the author found data on homeless figures throughout the United States, and according to the United States Department of Housing and Urban Development (2020), in the year 2020, there were a total of 580,466 homeless people in the United States, with 354,386 living in shelters, and 226,080 living in unsheltered environments. The further breakdown included Los Angeles County with 63,706 and San Bernardino County with 3,125 total people experiencing homelessness (U.S. Department of Housing and Urban Development, 2020). Additionally, the homeless trend is growing. Between 2019 and 2020, nationwide homelessness increased by 12,751 people (United States Department of Housing and Urban Development, 2020).

Given these numbers, it is clear that homelessness is a significant problem within California and throughout the United States. These numbers will likely transfer to most major cities and urban areas, as well as smaller areas adjacent to larger cities where it is possible that people traveling from these areas become homeless, finding themselves without jobs, money, shelter, or

other resources. HUD's report further breaks down the homeless data to include age, ethnicity, and gender (including transgender and gender non-conforming), but it does not include any information on sexual orientation.

Mental Health and Lack of Services

One of the first causes and contributors to homelessness was the closing of state mental hospitals back in the 1980's which was due to reductions in public spending on welfare. This resulted in an increased number of mentally ill people who were homeless (Dear & Wolch, 1987). Once having nowhere to go, deinstitutionalized people tended to drift toward larger city neighborhoods (Rukmana, 2011). This gives credence to the data by HUD which indicates that the largest number of homeless individuals are in the larger metropolitan areas such as New York City and County, Los Angeles City and County, and Seattle and King County (United States Department of Housing and Urban Development, 2020). Individuals who have mental health problems and are unable to obtain services are also likely to have problems maintaining housing for a variety of reasons including the inability to keep steady employment and living at or below the poverty level. It would appear that community mental health systems would protect against homelessness, but these organizations lack coordination and are disproportionately funded across different areas and affordable housing set aside for people with serious mental illness has proven to be inadequate and inconsistent (Wong & Stanhope, 2009).

Substance Abuse

Though substance abuse is a mental health issue, it may account for more people becoming homeless than other mental health issues by themselves. In a study by (Phillips, 2015), the authors asked 115 graduate school students how likely they felt having a problem with substance abuse would contribute to homelessness. Their responses were: likely (62.60%) and probably likely (40.87%). Substance abuse affects every aspect of a person's life beginning with their ability to maintain employment (Chamberlin and Johnson, 2011), which in turn can put economic stress on the individual, placing them at risk of poverty, losing their housing, and domestic violence. In the 1980s, the National Institute of Mental Health awarded research grants for a second generation of studies featuring methodological improvements over previous studies (Tessler & Dennis, 1992). In a review of these studies, it was found that 47-50% of the single adult homeless population had a substance abuse disorder at some point in their lives (Lehman & Cordray, 1993).

Job Loss and Continued Unemployment

Job loss by itself can be a contributing factor to becoming homeless. After a job loss, individuals will try to reduce household expenses, borrow money from family or friends, and begin using credit cards. Households that previously had low incomes before the job loss of the primary money earner, may not have enough savings to get them through an extended period of unemployment and might lose their housing during this time (Chamberlin & Johnson, 2011). If a job

loss occurs suddenly, even someone who previously earned a good living might find it hard to reduce expenses and spend quickly enough to avoid becoming homeless.

Homelessness can also perpetuate continued joblessness because homeless individuals usually have no place where they can receive mail, have no computers to create resumes, nor have cell phones where potential employers can contact them. Employment has the potential to improve the quality of life and reduce the risk of homelessness (Lam & Rosenheck, 2000). This indicates that employment is an important means of ending an individual's homeless cycle, so it should be a priority (Shaheen & Rio, 2007).

Family Breakdown

According to Chamberlin and Johnson (2011), family breakdown often occurs within the scope of two different patterns: the first might be caused by the end of a marriage or another significant relationship, the death of a spouse, the death of a parent, or children leaving the home; the second area identified has to do with domestic violence. Couples who previously relied on one another, adult children who were taking care of their elderly parents, or older parents who previously relied on their children to provide extra income, might find themselves homeless. And the recipient of domestic violence might stay in a relationship longer than they should have because they were dependent on the perpetrator. When they finally decide to leave, they can easily find themselves homeless or in a homeless shelter (Chamberlin & Johnson, 2011)

Lack of Affordable Housing

The lack of, or limited amount of affordable housing available can contribute to homelessness as well. In the (Phillips, 2015) study, 23.48% of the 114 respondents surveyed felt that limited affordable housing was a contributor to homelessness, while 48.70% felt that it was probably likely. Homeless people tend to migrate to larger urban areas where the cost of living is already high. As real estate prices continue to increase along with the demand for rental housing in larger cities, affordable housing is likely to become less and less available in the future.

The gap between housing costs in California as compared to the rest of the United States began to widen in the early 1970's and between 1970 and 1980, California home prices went from thirty to more than 80 percent above national levels (California's High Housing Costs, 2015) According to a report published by the State of California, at the time of publishing, the average rental cost in the United States was $840, while the average cost to buy a home in the United States was $179,000 (California's High Housing Costs, 2015).

In this same publication, the average rent in the State of California was $1240 per month and the average cost to purchase a home in California was $437,000 (California's High Housing Costs, 2015). Even though the costs to rent and buy in the Riverside County area (where the Coachella Valley is located) are lower than the California average, the average rental cost was still $1080 per

month and the average cost to buy a home there is $284,000 (California's High Housing Costs, 2015).

Impacts and Consequences

Individuals experiencing homelessness are cut off from society and usually have no social support from family, friends, or the community. They also experience stigma, ostracization from society, greater health problems, and shorter life spans (Rokach, 2004). The costs to society can be looked at in terms of homeless individuals using emergency room services, and property values decreasing where large numbers of homeless people are living on the streets (Darrah-Okike et al., 2018). Additional costs to society include policing the homeless and the resulting costs associated with criminalizing homeless people for not having a place to live.

The societal costs associated with chronic homelessness stem from the fact that many homeless people have a serious mental illness, substance use disorder, physical disability, or chronic disease (Burt, 2002). These conditions can often present themselves as co-occurring disorders and these complex conditions often result in the homeless population using emergency shelters, acute health care, behavioral health care, criminal justice involvement, and use of other social services which can cost tens of thousands of dollars annually per individual (McLaughlin, 2011).

Existing Interventions

There appears to be a lack of prevention programs made available to keep people from becoming homeless. Since this study is about individuals who are already homeless, the focus will be on intervention rather than prevention. The most significant interventions believed likely to help the homeless include residential programs, job training programs, mental health treatment, educational programs, drug and alcohol treatment, medical care, homeless shelters, and programs that provide low-cost housing and outreach services in shelters (Phillips, 2015).

Many of these interventions tie back to the causes and conditions that create homelessness and they seek to address those needs that were not previously met, to move the homeless individual toward independent and secure housing. Likely the largest obstacle to interventions is a lack of funding and until recently, most funds allocated went to emergency shelters. This trend is changing (Brown et al., 2017). With these changes in intervention strategies that focus on interventions that more directly address the causes and conditions of homelessness, better outcomes are likely to occur.

There have been studies taking place since the 1990's that utilize empowerment theory in helping chronically homeless individuals find housing. One of these models is Housing First. Housing First is an evidence-based supported housing intervention for homeless adults with psychiatric and/or addiction issues and was first developed at Pathways to Housing in 1992

(Tsemberis & Asmussen, 1999). Unlike traditional social service models, which involved treatment-first, or continuum of care (CoC), Housing First offers homeless adults scatter-site housing, case management, and consumer-driven support (Tsemberis, 2010).

Treatment first and CoC models require that clients go through various supportive housing arrangements where the level of support depends on the client's housing readiness rather than getting them housing whether or not they are sober or accepting treatment for mental health concerns (Gulcur et al., 2003). Finally, existing research indicates that homeless interventions with empowering features are effective at meeting the needs of homeless individuals in meeting their housing and recovery goals (Nelson et al., 2007).

According to Shlay & Rossi (1992), most services for the homeless population are designed to meet emergency needs such as food or shelter or target narrow problem areas such as substance abuse, mental illness, or physical health. It is also believed that these types of services do little to solve the multitude of problems that homeless individuals face and that more comprehensive services are required (Acosta & Toro, 2000). To fill in the gaps these traditional emergency services supply, a study using the Demonstration Employment Project – Training and Housing (DEPTH) model took a holistic approach that combined services concerned with job training and placement and locating permanent housing and support services, all targeted to the individual's specific needs and oriented toward the long-term goal of helping the person

escape homelessness (Toro et al., 1997). One of the most marked differences between DEPTH's services and others was that it involved intensive case management. Those responsible for case management duties provided access and linkage services to financial aid, housing support, counseling for drug and alcohol problems, mental health assessment and treatment, and job training. Finally, when a needed service could not be provided in a specific community, DEPTH would provide it – an example of which might be loaning funds for move-in costs for apartment housing or helping clients with donated, furniture, appliances, and even finding daycare for their children (Toro et al., 1997).

Social Work Theories

The main social work theory that guided this research project is Maslow's Hierarchy of Needs. Maslow's theory posits that human beings must have their basic needs met before they can begin to get other, higher needs met (Best et al., 2008). Maslow's theory contains five human needs beginning with physiological needs, safety needs, belonging needs, esteem needs, and self-actualization. Looking at the theory through the lens of homelessness, it is understood that homeless individuals struggle daily to get their physiological needs met, so they remain at that level. If a person does not have basic needs filled like food and shelter, there is no possibility for them to seek the next highest need, safety.

In terms of treatment interventions for homeless individuals, Maslow's theory tells us that "lower-level interventions must precede higher-order ones,

and that higher-order needs are unlikely to occur in the early stages of treatment" (Best et al., 2008). Once homeless individuals begin some sort of treatment and their physiological needs are met though getting them off the street into some sort of program, detoxing them from drugs if necessary, and prescribing of mental health medications, the treatment efforts can then begin to look at issues of safety, belonging, esteem, and addressing more spiritual needs (Best et al., 2008).

Summary

Through the process of the literature review, the researcher found that prevention measures were more difficult to find so the focus has been on identifying interventions that have been used in attempts to serve the chronically homeless population in different localities in the United States and other similar countries. As noted, most of the interventions are emergency-based and seem to have little long-term effect on reducing the number of homeless individuals caught in the long-term cycle of chronic homelessness. Causes and conditions that bring about homelessness are shown to include mental health and lack of mental health services, substance abuse, job loss, continued unemployment, family breakdown, and lack of affordable housing. Society bears the costs of chronic homelessness through the use of services such as emergency shelters, and emergency rooms, and the costs associated with being involved in the criminal justice system.

Some literature noted that treatment first and continuum of care services do not always succeed because they require that the person achieve sobriety or mental health stability before being able to access housing. This can be a problem when a lack of sobriety and mental health stability might be caused by homelessness and not the other way around. Finally, case management-intensive programs such as DEPTH, have worked to provide access and linkage to housing and related services such as job training, financial aid, mental health, substance use assessments, and even short-term loans and daycare for clients actively receiving services to ameliorate their homelessness.

It is hoped that the data from this study will fill in gaps in the literature, as most of the data found were quantitative. The qualitative constructions developed during this process will also help expand findings from other areas to include the Coachella Valley, and hopefully serve as a road map to provide better services in this, and other similar localities.

CHAPTER THREE

METHODS

Introduction

This study sought to identify the needs of individuals within the homeless population as seen by MSW students who currently work with this population in either their regular employment or in their MSW internship role. The participants helped explore and identify not only needs, but services and interventions that the study participants believed succeeded or failed to meet these identified needs. Finally, the participants were asked to identify new services and interventions that they would implement if they were in a position to do so without restrictions. This section that follows includes the study design, sampling, data collection and data collection instruments, procedures, protection of human subjects, and data analysis.

Study Design

The study was a mixed-methods project including quantitative and qualitative data. The quantitative data was compiled through the use of a Qualtrics survey instrument that was emailed to all MSW students who were enrolled during the Fall 2023 semester. The survey gathered preliminary data including the verification that the MSW students met the initial requirements for participation. These participant requirements included being an MSW student at the time the survey was made available, working and/or interning in the human

services field, and working and/or interning at an organization that provided services to homeless individuals and/or families. Demographic data was also obtained from survey participants including gender, age, race, ethnicity, length of time working in the field, length of time at current job, the type of organization, organization funding sources, average length a client receives services, and any time limits that clients are able to obtain services from the agency.

Sampling

The researcher utilized purposeful sampling, directing the focus toward participants who were current MSW students. The reasoning behind the use of purposeful sampling stemmed from the belief that current MSW students who worked with the homeless population would have a new and unique understanding of the types of needs their clients presented with, along with an understanding of the gaps in service delivery. According to Palinkas et al., (2013), purposeful sampling is frequently used in qualitative research to obtain information-rich data from limited resources. It also utilizes individuals who are knowledgeable in specifically desirable areas of interest (Palinkas et al., 2013). It was also believed that they would have a fresh perspective of what new interventions might be implemented to fill in these service gaps that fail to meet the needs of the homeless population being served.

With purposeful sampling, the goal of participant selection is to identify and select specific cases that meet the predetermined criterion of the participants being sought. This sampling is referred to as “Criterion-i” purposeful sampling

(Palinkas et al., 2015). With this type of sampling, the researcher does not expect that the data from this study will be transferable to other populations, nor will a similar research study be likely to obtain the same results.

Data Collection and Instruments

Data collection was conducted in two distinct phases. Phase One, as mentioned in Study Design, provided a survey to MSW students enrolled in the Fall 2023 semester. After IRB approval was received, a research participation request with a link to the Qualtrics survey was sent via email to all current MSW students enrolled at that time. The email also included a link to the Survey Informed Consent Document. The last question of the survey asked the respondent to participate in a qualitative interview via the Zoom platform and requested the email address of respondents who were willing to participate in the interview. A total of eleven surveys were received, eight respondents answered all questions, three participants provided incomplete responses, and six respondents agreed to participate in the qualitative interview.

The researcher contacted each respondent who agreed to participate in the qualitative interviews and sent each one an informed consent document for the interview. No interview took place until the informed consent documents were returned to the researcher. The six qualitative interviews were conducted via the Zoom platform with audio and video being recorded. Each interview took from thirty to sixty minutes to complete. All clients were asked the same eight

questions which can be found in Appendix C, and the researcher asked follow-up questions whenever necessary.

Procedures

When the principal investigator and researcher determined that data collection had reached a saturation point, gathering no new qualitative data, the researcher began the process of reviewing data and preparing it for analysis. First, the Qualtrics survey data was downloaded to a Portable Document File (PDF) for data review. Each interview audio recording was then imported into Microsoft Word and each resulting transcript was individually saved and password protected.

Protection of Human Subjects

The Qualtrics instrument was used to protect the human subjects who chose to participate in the initial survey. Qualtrics survey data is password protected and only the researchers had access to the data submissions. Those respondents who indicated that they would like to participate in the qualitative interview had their email addresses recorded in a password protected Microsoft Word file on the researcher's computer. To protect the identity of the interview participants, each transcript was named using generic nomenclature that would not identify the participants. These transcripts were password protected on the researcher's computer prior to beginning the data coding process.

Data Analysis

The data was analyzed using a “bottom-up” approach with no expectation of the data provided by the participants. The researcher first used open coding, reflecting upon, and categorizing the data provided by the interview participants. The transcripts were reviewed two times using this procedure to make sure all common themes and differences were identified. Then axial coding was employed to draw connections between the different codes found. The final portion of the analysis broke the data into units, and each unit was numbered, and data categorized, looking for common themes, and outlier data.

CHAPTER FOUR

RESULTS

Interview Participant Demographics

There was a total of 13 respondents to the Qualtrics survey that was sent to MSW students at the beginning of the Fall 2023 semester. Of that number, 2 surveys were incomplete, leaving a total of 11 full completed surveys. For a list of survey questions, refer to Appendix B. As seen in Table 1, the breakdown of survey participants was as follows: participant gender was 3 males and 8 females, the age of survey participants was 1 (age 18-15) 7 (25-35), 3 (45-55), the race of survey participants was 1 (Black), 4 (Hispanic) and 6 (White), the ethnicity that study participants was 1 (African American), 1 (Chicano), 1 (European American), 1 (Hispanic), 1 (Latino), 1 (Mestizo), and 1 (Mexican American), the length of time that study participants had been working in the human services field was 1 (less than 1 year), 3 (1-2 years), 3 (2-5 years), 3 (5-10 years), and 1 (10-20 years), the length of time that study participants had been working at their current job was 2 (less than 1 year), 8 (2-5 years), and 1 (1-20 years), the type of organization that study participants were currently working for was 6 (government agency), 3 (non-profit), 1 (for profit), and 1 (other), the survey respondents reported that their organizational funding came from 3 (county), 1 (county and state), 1 (donations, private insurance, cash), 2 (government), 1 (Medicaid, private investors, county), 1 (MHSA, state, county), 1(public, federal, private funding), and 1 (no response), the average length of

time that clients received services was 5 (less than 6 months), 2 (7-12 months), 1 (13-24 months), and 2 (over 24 months), and the final survey question asked whether there were limitations time limitations on clients receiving services and 6 respondents reported that there were time limits, and 5 respondents reported that there were no time limits.

Out of the total number of 11 survey respondents, 6 participated in a structured qualitative interview and the results of those interviews are broken down by interview question in individual headings. See Appendix C for the interview questions provided to each interview participant.

Client Population Demographics

The homeless populations being served by interview participants were between the ages of 18 and 70 years old. None of the interview participants worked with children, though one facility did have children under 18 present, but only with their mothers who were receiving services. The majority of clients served were unemployed or, at minimum, underemployed and came from lower socio-economic backgrounds. One participant stated, “my clients are more likely to be men than women at about a rate of 2:1.”

Clients presented with a diverse range of sexual and gender identities, and identifying as gay, lesbian, bisexual, non-binary, transgender, and queer. Some clients came straight from prison, were currently or previously involved in street life, gang culture, and drug culture. Clients presented with differing levels

of education, from not completing high school to having earned a master's level education.

Depending on the location of the interview participant's dent's employment, the race and ethnicity of the client's varied widely. Those interview participants who worked in larger metropolitan areas found a more varied demographic of clients, including Caucasian, Hispanic, Black, and others including Asian, Native American, and Pacific Islanders. In the more rural areas, one participant reported that "my client demographics were more likely to be Caucasian with a much smaller number of Black clients."

The most common source of treatment payment sources described by interview participants was Medi-Cal, which is federally funded through Medicaid, and state funded by county in the state of California. While the vast majority of homeless clients served were in treatment voluntarily, one interview participant said they worked "only with clients who were deemed "gravely disabled," were previous homeless, and were now under conservatorship at my organization." Homeless clients with typical health insurance or being funded as "private pay" were the least common the least common source of payments for client services.

Client Presentation/Needs

All interview participants reported that the majority of their clients presented with and needed treatment for either a substance use disorder or mental health disorder, or both.

> A participant stated, “other than substance abuse, we are looking at varying degrees of other mental health disorders, housing needs, medical concerns, clients who have varied levels of education, and ones in need of support for legal issues and CPS cases.”

With these dual diagnosis clients, the most common substance use was alcohol, followed by Heroin or other opiates such as Fentanyl, cocaine, methamphetamine, cocaine, and prescription drugs, the most common being benzodiazepines. Mental health presentations most often found were depression, anxiety, trauma, bipolar disorder, PTSD, as well as personality disorders such as anti-social personality disorder, borderline personality disorder, delusional disorder, schizophrenia, and schizoaffective disorder. A significant number of interview participants reported that many of their clients were victims of domestic or sexual violence and that women were far more likely to have been a victim of both.

> A participant stated, “while working with those in jail populations, I see quite a number of individuals with depression and anxiety, and a handful with schizophrenia, but the most common presentations include symptoms of trauma and PTSD.”

While these disorders are often the cause of client homelessness, it was reported that they are often the result of being homeless. Next to substance use and mental health disorders, all interview participants indicated that the majority of their clients presented with housing needs, need for greater education and

lack of vocational skills, legal issues, and CPS cases with children in foster care. Interview participants reported that clients found it difficult to remain abstinent from drugs when their basic needs were not being met, as a participant stated, “they were starting all over again.”

Mentioned above, many of the interview participants reported that their clients presented with a variety of legal problems ranging from petty theft to grand theft/burglary, to complex CPS cases where the client’s children were in foster care and the parents risked losing custody of their children permanently, while attempting to meet the requirements for family reunification. In addition to all these, homeless clients presented with a lack of knowledge for community resources in their areas, access to food, and lacking identification, social security cards, places to receive mail, and lack of transportation to/from medical and psych appointments. The final common theme in presenting needs related to cognitive impairments, hygiene, client aggression, and clients believing they do not need medication in spite of mental health diagnoses that clients often tried to self-medicate with alcohol and other substances, instead of taking mental health provider prescribed medications.

> A participant stated, “clients lack knowledge of community resources and medication management and typically begin using illicit substances again when they run out of or are unable to obtain their mental health medications.”

Client Services and Interventions

Inpatient Services

The services and interventions available to interview participants homeless clients were highly dependent on the type or organization providing services. Two interview participants were employed in dual diagnosis substance abuse residential treatment facilities, and the services and interventions described by each interview participant were similar. At each of these facilities, clients were provided with a place to live, so they were no longer homeless. Treatment length generally varied from one to four months, depending on the needs of the client.

While in residential treatment, clients worked with substance abuse counselors, therapists, medical/nursing staff, and were able to meet with a psychiatrist for medication management. Clients participated in process groups, psychoeducational groups on a variety of topics including substance abuse education, relapse prevention, and teaching clients the importance of treating both their substance abuse and mental health issues at the same time.

> A participant stated, “in the residential treatment center where I am employed, our focus is greater on the client’s substance abuse problem, but we also understand that a client’s ability to remain sober is highly dependent on treating their mental health concerns as well.”

Clients also participated in specialized groups on topics such as healthy relationships, anger management, and trauma. Clients were also able to participate in specialized training such as career counseling, resume building and mock interviewing techniques to prepare the client for later job search endeavors.

> A participant stated, “our clients often present with few life skills and a history of trauma, so we provide psychoeducational groups on topics such as boundaries and healthy relationships, how to deal with anger in healthier ways, and evidenced-based trauma groups such as Seeking Safety.”

Finally, clients were provided with case management services which included treatment planning, legal/court coordination, transportation to outside medical appointments, and discharge planning linking clients with local sober living environments when their treatment episode was completed. Clients were also referred to outpatient services in the areas where they discharge to, and in one of these locations, clients were also provided with identification and bus pass vouchers so clients could obtain these important items necessary for a successful transition from treatment into the community. In both locations, clients were linked with cellphones that are provided to low-income individuals.

> A participant stated, “it’s our goal to set up or link clients with services they will need after discharge.”

Inpatient Facilities with Mothers and Minor Children

Only one interview participant reported that their facility specifically housed only previously homeless mothers with their minor children. This facility in Northern California housed up to 350 individuals and women with dependent children could stay in the program for up to 2 years. Women were provided a wide range of services that other residential facilities offered, but also included helping the resident women who had not graduated from high school get their GED. Women with children would get their own dorm rooms and dorms held from 4-6 people. Unfortunately, during the height of the COVID 19 pandemic, their census numbers were much lower than 350 due to the safety requirements. The facility linked clients with vocational training such as welding or cosmetology and worked closely with clients and CPS workers to facilitate child reunification efforts for residents who had children in the foster care system.

> A participant stated, “our services are primarily focused on the mothers, but we have also had services to meet the needs of their minor children while their mothers are busy with programming, work, or community responsibilities.”

The facility had transportation throughout the large campus area and provided bus tokens to clients needing to travel outside the facility for other services. The most unique program this facility offered was community-based childcare. Residents could volunteer to provide childcare for resident peers who had jobs

outside the facility, provided they meet specific program criteria. This allowed women who were further advanced in the program to work in the community.

Outpatient and Other Services

While similar to services and interventions in a residential treatment environment, outpatient treatment services for homeless individuals had some significant differences. Many of these outpatient locations had several tiers of clinical employees working with clients. These include psychiatrists, therapists, social workers, nursing staff, and peer support specialists. One location even had a mental health specialist and parent/family advocates to provide education and support to family members.

> A participant stated that “our clients have access to a wide range of services including substance abuse counseling, individual and group therapy, medication management and programs that seek to educate and support the family members of clients.”

All outpatient locations provided psychoeducation and therapeutic process sessions and employees would meet clients wherever the client felt most comfortable. Often clients with severe mental health problems were uncomfortable in large outpatient facilities, so employees would meet clients in their homes or even public locations such as a coffee shop when necessary. Most all outpatient locations provided services in English and Spanish as very often clients were bilingual but their extended families were not.

Organizational Barriers to Services

Organization barriers to client services were similar across all types of service locations where survey participants were employed. The most common barriers noted were that of staff shortages, shortages of educated and qualified employees, and high turnover. Funding was also reported as being a barrier across all types of locations and all types of funding including Medi-Cal, private insurance, and donor-based funding. Availability of beds and wait times to enter treatment were also common barriers. All types of facilities were limited by the allowable treatment time available with private insurance being the most restrictive, followed by Medi-Cal, and other government funding.

> A participant said “while Medi-Cal clients are approved for longer periods of treatment times, private insurance companies are more rigid in their approval processes we often find that we have to move clients to a lower level of care prior to them being ready.”

The advent of the COVID 19 pandemic severely impacted the internal policies of inpatient and outpatient locations, limiting the number of beds, having the necessity of quarantining clients who tested positive for COVID 19, and reducing or eliminating the ability for family and friends to visit clients who were in a residential treatment environment. Also taking clients to outside appointments or recovery related events was curtailed or completely stopped during the height of the pandemic.

It was reported by several interview participants that the bureaucratic nature of county-funded Medi-Cal treatment presented problems because screening and assessments were often done at the county level for a small number of locations. Clients were also unable to initiate services while in jail, requiring them to be released and seek services and this gap often resulted in consumers returning to homelessness, substance abuse, and crime behaviors.

> A participant reported that “it’s difficult that we cannot see clients while they are in jail, so they are released, become homeless again, and have to find us to seek services.”

Client Barriers to Service

Client barriers to services were similar across all types of facilities where interview participants were employed. Client motivation to change was the biggest barrier found, “our clients often lacked motivation for change or did not believe they needed to change at all.” They were also found to have little outside support to motivate them to get help. The bureaucratic nature of service providers made it difficult for clients to move through the many processes required to enter into the treatment process.

Women with families and children often choose not to enter treatment due to their familial responsibilities. Clients who have pets are also less likely to enter treatment if there is no one available to care for them. Clients often refuse to leave their jobs to start treatment services for fear their jobs will not be waiting for them after they complete, and even though there are laws that protect them, they

are usually unaware of these statutes. “Our clients can come up with almost any reason to avoid getting help.” Most clients have little to no financial resources so they often choose not to engage in treatment for fear their bills will not get paid.

Other barriers include clients having full autonomy to make unhealthy choices after leaving treatment, which results in recidivism, their lack of willingness to participate in treatment activities, doing the bare minimum to get through the process, and breaking facility rules such as using substances while engaged in treatment activities. The residential treatment facilities reported having language barriers. Clients having had previous negative experiences with providers tend to limit involvement, enabling families, or a lack of family involvement altogether.

One interview participants reported that the biggest client obstacle to treatment was a client’s not even realizing that they were ill. These clients included ones who were not medication compliant, resulting in a recurrence or worsening of their symptoms. “Our clients often do not know how sick they really are.” Clients were found to lack transportation to and from appointments, lack computers, email access, and a home address for mail and job search purposes. Finally, clients often failed to seek out continuing care after completing residential or outpatient treatment programs which often resulted in recidivism back into the system of care where they started from.

Organizational Successes

The organizational successes that the interview participants noted were more varied than answers to some of the other questions. Common to all residential treatment organizations, each interview participant felt that their organization met the basic needs of their clients, including housing, three meals per day, in a location that is safe, away from the elements of homelessness. “A residential treatment environment helps resolve lack of shelter, food, and safety or our clients.” Many homeless clients came to treatment with court cases and all organizations helped them with their legal issues by providing transportation to and from court appearances. They helped them with getting set up with State Disability Insurance (SDI), got them enrolled in Medi-Cal services if not already, helped them obtain free or reduced rate cellular telephones, and helped them get enrolled in food stamp and cash aid programs prior to their discharge. At one site, the organization had a walk-in detox center, and clients could be admitted directly if there we enough beds available, then transfer to residential treatment after completion.

> A participant said, “very few places offer walk-in detox services, instead they have to go through more complex admission procedures days ahead of being admitted.”

It was reported in one county that they implemented a “no wrong door policy” for outpatient clients which allowed consumers to show up at any county behavioral

health office and initiate services rather than having to start by calling a county toll-free number.

In the program that specialized in helping mothers with children get out of their homeless cycle, the participant reported that the facility designed and set up course work for other transitional shelters across the country to implement, saying “we provide other agencies with our in-house developed curriculum.” They offer literacy and math programs for the children of residents, social and emotional learning and science clubs as well. The organization continually strove to support the educational and emotional needs of their clients and children, knowing that when the mother’s lives improve, the lives of her children do as well. This organization also had a less restrictive policy on drug usage. Though substances were forbidden on the campus, mothers who tested positive for drugs were not removed from the program but instead were provided with more substance use disorder education.

The outpatient organizations, though not always geared to provide some of the basic services mentioned above, provided specialized services that interview participants felt were successfully implemented. Mentioned by two interview participants was their organizations having bilingual staff and having materials in both English and Spanish.

> The participant said, “having bilingual staff like we do in the larger cities is helpful because many client’s and their families speak Spanish.”

Interview participants reported helping clients fill out paperwork and going above and beyond their required job roles whenever possible. The outpatient providers had teams that worked in the field seeking out homeless individuals who were interested in obtaining services.

One of the most important aspects of a successful intervention was meeting clients where they were. Allowing clients the autonomy to decide for themselves which services they wanted to avail themselves, and then having the professionals accept them and their choices. Each organization believed that medication autonomy was equally as important as clients were not forced to be on medication for mental health if they did not wish to be.

> One participant said, “it can be really hard to let people make decisions for themselves that might not be in their best interests.”

As long as they were not breaking rules or presenting dangerous behaviors to staff or other clients, clients were free to make choices whether or not to take medication. Finally, for clients who were on medication by choice, the organizations worked diligently to teach clients how their medications work, and helped to monitor medication effectiveness, compliance, and the interactions of multiple medications.

Organizational Failures

Interview participants were candid in their willingness to discuss organizational failures due to the anonymity of the project. In the residential treatment environment, interview participants reported that their programs were

just a short-term solution with limited treatment episodes. Clients could obtain services for 2-3 months and were stepped down to a lower level of care with another agency. Even though clients were assisted with outpatient and sober living referrals, even those lasted no more than 3 months. Also reported was a lack of long-term care for clients with serious mental health issues.

> “I wish we could get funding for longer term care because I think it takes about a full year before client changes take root.”

Often these clients were discharged from outpatient services or asked to leave sober living environments for a variety of reasons and they end up starting over again in the system. It was reported that there were not enough sober living beds to provide safe shelter for the number of clients coming out of treatment.

A common organizational failure included “one size fits all” type of treatment programs, which were known to fail at helping clients who have more complex mental health problems. Along with this, interview participants reported a lack of accountability for clients who do the minimum possible work to get a completed discharge. This can have a negative effect on the morale of clients who work hard to achieve their goals.

> “A lot of clients just do the minimum necessary to complete treatment, while others work much harder. I wish we could weed out the unmotivated ones so we could serve more clients.”

Another organizational failure reported had to do with keeping clients healthy, especially since the advent of the COVID-19 pandemic. Most organizations implemented stringent testing and quarantine policies during the pandemic, and many of them completely stopped seeing clients in their outpatient clinics. Family visitation was stopped in most residential treatment programs and client outings were curtailed as well. Now that the worst of the pandemic is over, organizations have resumed visitation and client outings and this has resulted in more people getting sick.

> “Especially in residential treatment, when one person gets sick, it spreads around pretty quickly. Staff who come into work with symptoms can also spread sickness.”

One interview participant noted that food banks were providing homeless clients with food items that needed refrigeration and/or items that were not useful to homeless individuals with no kitchen or place to store food. Finally, organizations of all types employed people who had a “not my job” mentality and would almost never go above and beyond the minimum amount of work required to keep themselves employed.

Innovative Solutions

This section of the results chapter is focused on the interview question that asked the interview participants what type of services and interventions they would implement if they were able to do so without restriction.

Within the residential treatment environment, research participants all noted that they wanted to have a greater length of time to provide services to their clients. Mentioned earlier, clients often go straight from residential treatment to outpatient and the large downward shift in the client level of care was often too great for clients to maintain their recovery. A plan for partial hospitalization with outpatient treatment was noted as being highly desirable.

Additionally, participants mentioned having greater access to a greater number of crisis stabilization units for individuals with acute, complex mental health problems, “there aren’t enough stabilization units in the area to handle clients in crisis,” as well as more availability of transitional services when moving from one level of care to another. Vocational training was also noted as an intervention that would help clients prepare for their life outside the treatment process. Most homeless individuals lack vocational skills and struggle to with employment after finishing their treatment episode.

> A participant said, “We help clients with many things but fall short in helping them seek employment for after they complete treatment. If clients cannot find jobs, they often end up relapsing and back in treatment again.”

One of the problems noted was a lack of continuity in services. Many agencies provide one type of service and not another. One interview participant noted that he believed having several levels of care at one location would provide this missing continuity of services.

> “Having services from detoxification to residential treatment, sober living, with intensive outpatient services on one agency site would provide a better level of continuity and would likely result in better client outcomes.”

More staffing was also noted as an important solution. At the facility serving women and their children, the study participant noted that the facility did not employ enough educated professionals. Also, it was suggested that they would implement more child-focused programs in addition to the mother-focused programs already in place.

> “We need a greater ratio of professional staff to clients” and these included therapists, medical staff, child psychologists, case managers, and drug and alcohol counselors.

As noted by several interview participants, greater follow up after client transition would be something they wanted to implement, along with more wrap-around twenty-four hours services, and more residential and outpatient providers for substance abuse and mental health.

Homeless shelters generally have strict requirements for entry and one interview participant noted that they would create more shelters with lower barriers for clients to enter them. Homeless shelters often require sobriety for entrance and homeless individuals often cannot pass a drug test for entry, so opening more shelters that do not require sobriety for access would help get more people off the street. Also, many shelters do not allow individuals to bring

their belongings with them, or a minimum, they must take their belongings with them when they leave, and these restrictions limit a homeless person's ability to utilize shelters for fear of losing their belongings. Finally, it was suggested that more shelters who allow clients with more extensive criminal records be opened as well.

Barriers to Innovative Solutions

The majority of barriers noted by study participants focused on the difficulty in obtaining funding for their innovative solutions. Depending on the type of business model, funding might need to come from government regulation or congressional laws, board of director approval, and donor funding. "One election can change the nature of services that we are able to provide." Next to financial barriers, facility space, staffing, and program accreditation were noted as well. Funding for any kind of treatment requires medical necessity, and it is hard to get approval for inpatient or partial hospitalization for the length of time needed to provide clients with the extended help they may truly need.

Other barriers noted included conservative social policy toward homeless and mothers living in poverty. Conservative beliefs often espouse a belief that homelessness, poverty, and drug addiction is a moral failing. Along with these beliefs are the "not in my backyard" mentality, and the location where services are being provided. "I think we really need to better educate society about the true nature of addiction and mental health." Services provided in larger urban areas tend to have more liberal ideas, whereas small rural areas tend to be more

conservative. A final point in the area of politics was noted that most people holding political office have never been homeless, in jail, and often do not see the connection between homelessness and treatment.

CHAPTER FIVE

DISCUSSION

Recapitulation of Study

This study sought to explore homelessness, the ways that people became homeless, their presenting needs, current social work interventions, and the exploration of newer and unique services and interventions that Master of Social Work students at California State University San Bernardino felt would help to better serve their homeless clients in areas where gaps in services were found to exist. Using a qualitative approach, the study interviewed 6 participants who were simultaneously working on their Master of Social Work degree and working with homeless individuals in their regular employment or their practicum setting. Though the researchers did not have specific findings they were looking for, it was expected and found that there existed gaps in services provided to the homeless individuals and that the study participants would have a unique perspective about where improvements in services could be made.

Consistency of the Findings with Prior Research

The literature review done prior to beginning this study indicated that there were several factors that appeared to be root causes of homelessness. These factors included mental health and lack of mental health services, substance abuse, job loss and continued unemployment, family breakdown, and a lack of affordable housing.

The researchers were able to confirm that individuals who had substance use and mental health problems also struggled to maintain housing (Wong & Stanhope, 2009), as found through the process of literature review. It was also found to be true that many of the organizations providing services to homeless individuals did so lacking coordination and consistency in funding (Wong & Stanhope, 2009).

Also consistent with the literature review, the researchers found that job loss and continued unemployment had a significant effect on becoming homeless (Chamberlin & Johnson, 2011), but also that most of the intervention solutions reported by study participants were not actively seeking to find their clients employment as an important means of ending their client's homelessness cycle (Shaheen & Rio, 2007).

Consistent with literature review findings, study participants reported that family breakdown was indeed a precursor to homelessness. Study participants reported that many of their clients had histories of experience domestic violence and found themselves homeless when they finally decided to leave their toxic relationship (Chamberlin & Johnson, 2011).

In terms of lack of affordable housing, many study participants indicated that their clients had been forced into or remained homeless because of the lack of affordable housing and this was consistent with the literature review as well (Phillips, 2015).

In terms of impacts and consequences of homelessness, research participants indicated that homeless people generally lacked social support and experienced stigma, disconnection from society, and greater health problems than their clients who were not homeless (Rokach, 2004), but none were able to confirm that their clients had shorter life spans.

There were both similarities and differences between the existing interventions noted in the literature review and the interventions being provided to clients of study participants. The main difference was that most intervention models used by study participants were of the Continuum of Care and Treatment First models. These models required that clients move through specific treatment modalities such as detox, residential treatment, education programs, drug testing, outpatient services, and more, in order to have their homelessness resolved (Tsemberis, 2010).

There were very few Housing First type models where it did not matter whether the homeless person was sober or not to participate. Only one study respondent out of six worked within a Housing First model where sobriety was not a requirement for services (Tsemberis & Asmussen, 1999).

Finally, the literature review found that most interventions for homeless people were meant to meet emergency needs of food and shelter and designed to target the narrow problem areas of substance abuse, mental illness, and physical health (Shlay & Rossi, 1994), and this proved to be common throughout the study findings. It appeared that these types of services helped significantly in

the short-term, they did little to solve the multitude of problems that homeless people fact and that, comprehensive services beyond 30-60-90 day, and even 6 months of services are needed in order help resolve the many problems that homeless individuals face (Acosta & Toro, 2000).

Implications for Theory

The findings in this study reflect Maslow's Hierarchy of Needs theory in that in order for individual to achieve higher levels of love/belonging, esteem, and self-actualization, their primary physiological, safety, and security needs must be met first. According to Maslow, human physiological needs include breathing, food, water, shelter, clothing, and sleep. With the exception of breathing, homeless individuals have difficulty in getting these needs met. In terms of safety and security, homeless individuals struggle to maintain health, employment, property, family and social support. The study findings were indictive that most services and interventions targeted for homeless individuals sought to meet these physiological and safety/security needs, and some even sought to fulfill needs in the love and belonging category which includes friendships, involving family in services, and building intimacy and a sense of connection to further enhance the lives of those receiving services.

Implications for Social Work Practice

Social workers have both an ethical responsibility as well as a genuine opportunity to protect the vulnerable homeless populations they serve. On a

micro level, social workers provide direct services and supports to help to eliminate or at least ameliorate the problems experienced by their homeless clients, while on the mezzo level, social workers can work within their communities to build coalitions that help to meet the needs of both the individual and the community. Finally, at the macro level, social workers can work to get legislation passed that will help to fund the provision of services and seek to work toward social justice by bringing some equity to those whose lives have been disrupted by homelessness.

Implications for Social Work Education

In terms of implications for social workers and social work education, this study has served to bring greater awareness and understanding of the needs that homeless people encounter and also the barriers that are faced both by the homeless individuals themselves, but also the social workers providing services to them. The study helped to bring forth the different factors that contribute to homelessness and bring awareness to the barriers that need to be overcome in order to provide the best services possible to those experiencing homelessness. It is also hoped that findings will serve to inspire social workers to make advocating and providing services to this vulnerable population a priority in their social work careers.

Implications for Research

Though this study was not designed with the ability to recreate the results in similar study, it still carries meaningful implications for future research on the subject of homelessness. As the study included both structural and personal barriers that lead to homelessness, it also included newly thought-out services and interventions as seen by MSW students to fill in the gaps in services where agencies are failing to meet the needs of the homeless populations they serve. It is the hope of the researchers that future research will be done on the efficacy of the new and innovative services brought to the forefront of this study by its social work students who participated, bringing their ideas forward.

Limitations

The most significant limitations of this study come from its inability to be recreated with similar results or for this study being transferable to a different population. This is due to the qualitative nature of the study and because the data, both objective and subjective, will likely vary by professional participants, geographic location, funding sources, and the varied and changing needs of the homeless populations being served. Finally, given the time-sensitive nature of the study, the data are limited due to only having 11 total survey respondents and 6 qualitative interviews.

Even with these limitations, the goals of this study were to spark a conversation with newly emerging social workers (currently MSW students) and to get them thinking about how they would approach measuring the needs and

services available to them as social workers serving homeless populations, and to help them apply critical thinking skills in evaluating interventions for success and attempt to bring new and innovative services and interventions to the forefront of homeless services in their current and future careers as social workers.

Recommendations

To further fill in the gaps that this research was unable to undertake, future research studies should look to incorporating both the clinical perspectives of homelessness as well as directly involving homeless individuals and families to get a better understanding of their own perspectives. Future studies should also attempt to engage more participants to bring greater breadth of knowledge to the subject matter. Finally, a study that provides an equal amount of quantitative and qualitative data would likely be more robust and give the body of research more specific data on the ever-changing role of social workers providing services to homeless populations in the United States.

APPENDIX A

RECRUITMENT EMAIL

Recruitment Email

My name is Mitchell Greenwald, and I am a third year MSW student. As my final research project, I have chosen to conduct a mixed method study of services provided to homeless individuals in social service agencies.

- To participate in the study, you must work with the homeless population in social services related employment
- There are two parts to this study: a Qualtrics Survey and a Qualitative Interview
- The survey will gather quantifiable data needed for background data
- The interview portion will gather a qualitative, detailed understanding of the homeless population served by participants who currently work with the homeless population
- The goal of the study is to determine which services appear to be benefiting this population and which ones appear to be falling short
- You do not need to participate in both parts, but to be eligible to participate in the interview portion, you will need to complete the Qualtrics survey first
- Individuals who also participate in the virtual qualitative interview will be entered into a drawing for a $50.00 Amazon gift card.

If you meet the criteria mentioned above and would like to participate, please click on the link below and provide your answers in the survey questionnaire.

If you would also like to participate in a qualitative virtual interview, please enter your email address in the appropriate section of the survey and the researcher will contact you to set up the virtual interview.

The estimated time to complete the initial survey questions is less than 15 minutes.

This research study has been approved by the CSUSB Institutional Review Board (IRB), Dr. Armando Barragan, and this email has been approved by Dr. Carolyn McAllister.

APPENDIX B

QUALIFYING AND SURVEY QUESTIONS

Qualifying Questions

1. Are you currently a student who works with homeless individuals?
   Yes/No
2. Are you currently working in the human services field?
   Yes/No
3. Does your organization work with clients who are homeless?
   Yes/No

Survey Questions

1. What is your gender?
   Male, Female, Non-Binary/Third Gender, Prefer not to Say.
2. How old are you?
   18-25, 25-35, 35-45, 45-55, 55-65, Older than 65.
3. What is your race?
   Asian, Black, Hispanic, Native, White, Other, Prefer not to Say.
4. How do you define your ethnicity?
   (Please Enter Response)
5. How long have you been working in the field?
   Less than 1 Year, 1-2 Years, 2-5 Years, 6-10 Years, 11-20 Years, Over 20 Years
6. How long have you been working at your current job?
   Less than 1 Year, 1-2 Years, 2-5 Years, 6-10 Years, 11-20 Years, Over 20 Years
7. What type of organization do you work for?
   Govt. Agency, Non-Profit, For-Profit, Other
8. Where does funding for your organization come from?
   (Please Enter Response)
9. What is the average length of time a client receives services?
   Less than 6 months, 7-12 Months, 13-24 months, Over 24 months
10. Is there a limit as to how much time a client can receive services?
    Yes/No

APPENDIX C

INTERVIEW QUESTIONS

Interview Questions

1. Describe the population that you serve in terms of age, gender, and culture.
2. What type of needs do your clients present with?
3. What kind of services are available to meet these needs?
4. What kind of barriers prevent clients from receiving services?
5. Please describe the ways you feel these services meet the client's needs.
6. Please describe the ways you feel these services fail to meet the client's needs.
7. What services would you implement if you were able to do so without restriction?
8. What are the barriers you are likely to encounter in your attempt to implement these services?

APPENDIX D

INFORMED CONSENT - SURVEY

Informed Consent - Survey

The study in which you are being asked to participate in is designed to examine the services available to homeless individuals. The study is being conducted by Mitchell Greenwald, a graduate student under the supervision of Dr. Armando Barragán, Associate Professor of Social work at California State University, San Bernardino (CSUSB). This study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to develop a better understanding of the services available to homeless individuals as understood by individuals who currently work in the social services field and with this population.

DESCRIPTION: Initially, participants will be asked a series of survey questions to gather demographic data on the respondents, as well as pertinent data regarding their experience in the social services field and in working with this population. Respondents will then be given the opportunity to opt into the study interview, where they will be able to answer a series of open-ended questions designed to gather a rich qualitative data set on the type of services they provide, as well as services they would implement if they were able to do so without restriction.

CONFIDENTIALITY: Your responses will remain confidential and data will be reported in group form only.

DURATION: It will take 5-10 minutes to complete the survey. If respondent chooses to participate in the optional qualitative interview, the estimated duration of the interview is 45-60 minutes.

RISKS: Although not anticipated, there may be some discomfort in answering some of the questions. You are not required to answer any of the survey questions, may skip questions, or end your participation entirely.

BENEFITS: There will not be any direct benefits to the participants. However, findings from the study will contribute to our knowledge in this area of research.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Barragán at (909) 537-3501.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu) at California State University, San Bernardino after July 2024.

By clicking on the Qualtrics link below, you agree to have your survey answers recorded and included in the study.

https://csusb.az1.qualtrics.com/jfe/form/SV_a4ALxildKSZqkvQ

APPENDIX E

INFORMED CONSENT - INTERVIEW

Informed Consent - Interview

The study in which you are being asked to participate in is designed to examine the services available to homeless individuals. The study is being conducted by Mitchell Greenwald, a graduate student under the supervision of Dr. Armando Barragán, Associate Professor of Social work at California State University, San Bernardino (CSUSB). This study has been approved by the Institutional Review Board at CSUSB.

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DURATION: It will take 5-10 minutes to complete the survey. If respondent chooses to participate in the optional qualitative interview, the estimated duration of the interview is 45-60 minutes.

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CONTACT: If you have any questions about this study, please feel free to contact Dr. Barragán at (909) 537-3501.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu) at California State University, San Bernardino after July 2024.

By answering the following question affirmatively, I agree to participate in a recorded interview:

_____ YES _____ NO

I understand that I must be 18 years of age or older to participate in this study, have read and understand the consent document and agree to abide by the study.

_____ _____

Place an X mark here Date

APPENDIX F

IRB APPROVAL

May 5, 2023

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2023-184

Armando Barragan Jr. Mitchell Greenwald
CSBS - Social Work, Users loaded with unmatched Organization affiliation.
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Armando Barragan Jr. Mitchell Greenwald:

Your application to use human subjects, titled “A Mixed Study of Services Available to Homeless Individuals as Seen by Social Workers Who Are Currently Enrolled MSW Students and Who Work with this Population ” has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has weighed the risks and benefits of the study to ensure the protection of human participants.

This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses. Investigators should consider the changing COVID-19 circumstances based on current CDC, California Department of Public Health, and campus guidance and submit appropriate protocol modifications to the IRB as needed. CSUSB campus and affiliate health screenings should be completed for all campus human research related activities. Human research activities conducted at off-campus sites should follow CDC, California Department of Public Health, and local guidance. See CSUSB's COVID-19 Prevention Plan for more information regarding campus requirements.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2023-184 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

King-To Yeung

King-To Yeung, Ph.D., IRB Chair
CSUSB Institutional Review Board

KY/MG

APPENDIX G

SURVEY SOCIO-DEMOGRAPHIC CHARACTERISTICS

Table 1. *Survey Socio-Demographic Characteristics*

	Total Sample (*N*=11)
Characteristics	*n* (%)
Identified Gender	
Male	3 (27.27)
Female	8 (72.73)
Age	
18-25	1 (9.09)
25-35	7 (63.64)
45-55	3 (27.27)
Race	
Black	1 (9.09)
Hispanic	4 (36.36)
White	6 (54.55)
Ethnicity	
African American	1 (9.09)
Chicano	1 (9.09)
European American	1 (9.09)
Hispanic	1 (9.09)
Latino	1 (9.09)
Mestizo	1 (9.09)
Mexican American	1 (9.09)
No Response	4 (9.09)
Length of Time Working in Field	
Less than 1 Year	1 (9.09)
1-2 Years	3 (27.27)
2-5 Years	3 (27.27)
5-10 Years	3 (27.27)
10-20 Years	1 (9.09)
Length of Time at Current Job	
Less than 1 Year	2 (18.18)
2-5 Years	8 (72.73)
10-20 Years	1 (9.09)
Type of Organization	
Government Agency	6 (54.55)
Non-Profit	3 (27.27)
For Profit	1 (9.09)
Other	1 (9.09)
Organization Funding	
County	3 (27.27)
County and State	1 (9.09)
Donations, Private Insurance, Cash Pay Clients, &	1 (9.09)
Government	2 (18.18)
Medicaid, Private Investors, County DMH	1 (9.09)
MHSA, State & County Funding	1 (9.09)
Public, Federal, & Private Funding, Donors	1 (9.09)
No Response	1 (9.09)
Average Length Client Receives Services (10 Responses)	
Less than 6 Months	5 (50.00)
7-12 Months	2 (20.00)
13-24 Months	1 (10.00)
Over 24 Months	(20.00)
Time Limits Client Receive Services?	
Yes	6 (55.00)
No	5 (45.00)

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